

Drug dependence in the United States of America

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'That humanity at large will ever be able to dispense
with artificial paradises seems very unlikely'

Aldous Huxley

THIS survey, undertaken in less than four weeks, does not claim to be a scientific study in depth. It is an attempt to explore the problem of drug taking in the USA, and show that it is not basically different from the situation in this country. It is easy to assume that national differences operate in the genesis of this disorder, but there is really no convincing evidence of this. Since reliable statistics do not exist, the actual size of the problem can be defined only approximately.

The survey was centred on two large areas only, namely New York and San Francisco. New York State consists of 62 counties with an estimated population (1969) of 18,210,000 persons in an area of 49,576 sq. miles. New York City has an estimated population of 10,694,633 although like San Francisco commuting is not only progressively reducing this figure but also produces a diurnal tidal flow. California has 58 counties with an estimated population of 19,734,000 contained in a land area of 158,693 sq. miles. The San Franciscan population figures have fallen from 775,357 in 1950 to an estimated 705,000 this year.

A more equal comparison can be made by considering San Francisco Metropolitan area which includes Oakland. The population here has risen from 2,135,934 in 1956 to an estimated 3,082,000 this year, within a land area of 2,478 sq. miles. Incidentally, the cars licensed in 1967 in New York State were 5,323,943 (population 18,210,000) and in the San Francisco Metropolitan area 1,559,867 (population 3,082,000).

Hard drug dependence

This type of dependence can be described as an addiction to morphine, heroin and cocaine.

In 1900 in the United States various opiates, including heroin, were incorporated in many patent medicines which were sold without prescription, and about 1 in every 400 persons was addicted, whereas today's figure is in the region of 1 in 2,000. The present difficulty is not that there is more heroin addiction than there used to be, but that the medical and social authorities have been unable to influence the growth rate of the problem during the last 10 to 15 years. There is said to be virtually no heroin addiction in any of the universities in the USA, the problem being largely that of the high school drop-out.

Hard drug dependence occurs mostly in the areas of decay within the large cities and 65-70 per cent of those who use these drugs are negroes, Mexicans or Puerto Ricans. New York City has more than 50 per cent of the total number in the United States, and in that city some 20-30 per cent of crimes against property are committed by heroin addicts, but they do not usually commit crimes of violence. The present estimated figure of hard-drug addicts in New York is 50,000. In San Francisco the small figure of 2,500 reflects the superior living conditions. Los Angeles is said to house the majority of addicts in California.

Soft drug dependence

By this is meant addiction to cannabis or marijuana, methedrine, amphetamines, barbiturates, nutmeg, morning glory seeds, cactus, mace, peyote, catnip (*Nepeta cataria*), glue sniffing, carbon tetrachloride, nitrous oxide, and any other substance that is known, or may be found, that will alter consciousness.

Actual figures are not available. The range of experimentation is infinite and the hippy chemists drawn from the ranks of undergraduate and postgraduate students concoct new substances at frequent intervals.

In New York State it is thought that 15 per cent of marijuana users reach hospital, but often because of multiple addiction rather than the cannabis itself. In San Francisco one centre for special problems has an estimated figure of 44,000 consultations annually for an addict population of around 9,000.

The order of popularity and frequency of usage is (1) cannabis, (2) methedrine, (3) others.

It has been estimated that among the student population aged between 18 and 21 years 70 per cent have smoked once, and that in the urban community 47–56 per cent have done likewise, but spread, both upwards to ages 30–40 and downwards to 12-year olds has been recently noted. Chronic smokers amongst students account for one quarter of the total and an increasing number of these drop out.

The most dangerous drugs in this category are (1) methedrine which used intravenously can lead to sudden death or psychotic states, commonly paranoia, and (2) hallucinogens, for example LSD and STP, which can cause psychosis and fatal accidents, for example jumping from windows. The hallucinogens are passing out of fashion because they are failing to produce the expected result and, possibly, their dangers have been recognized.

During the first nine months of 1967 the Langley Porter Institute in San Francisco treated 4,750 LSD and methedrine addicts. This unit is a particularly sophisticated example of what can be done in the handling of soft drug dependents. Patients are referred to the unit by local doctors, clinics, and hospitals and less frequently by schools, parole officers, community agents, former patients, friends and parents. An appointment for evaluation purposes is given to any applicant. The system is entirely voluntary and patients addicted to hard drugs are not accepted. The patient must agree to take no drugs other than those prescribed by physicians in the unit. The period of stay is generally two to three months.

If the patient has a family living within reasonable distance, parents and relations are required to attend family therapy sessions at regular intervals. Candidates for admission and if possible their families, meet with an admission team which is composed of two members of the staff and two inpatients.

At the time of admission, patients will be told about the rules and operation of the ward and will be explicitly informed that they must complete certain requirements within a certain time limit. For example a basic psychological test, an initial video-tape monologue, a written autobiography and a self-presentation to the community must be completed within the first week. A personal film should be completed before the end of the first month. Patients must agree to attend all groups on time every day, and they are expected to take part in all scheduled ward activities.

Except in unusual situations no individual psychotherapy is used and group activities are predominant. Progress is assessed by the following method: After one month each patient appears before an evaluation team again composed of two members of staff and two patients. Appropriate recommendations are then made for the next month's stay. At some time in the second month of the patient's stay in the ward he

will meet a discharge team of two staff and two patient members to make recommendations for the discharge date and help with after-care plans.

Dates of discharge or plans for transferring a patient to another hospital are not final until approved by the unit director. Patients are expected to make arrangements for living outside the hospital as soon as they can and to seek employment as soon as possible thereafter. If they wish they are placed on an after-care status at the time of discharge. After-care patients are all assigned to one member of the staff and they are expected to attend the weekly after-care group and family therapy sessions.

The main emphasis in therapy is in small and large groups, family therapy, occupational therapy, psychodrama, and seminars. A strong emphasis is placed on 'mobilizing the creative potential of all patients through the use of television, film, music, creative writing, art and so forth. This is called multi-media therapy.' This structure is defined as a therapeutic community and its exact definition is as stated in the unit brochure:

Maximum freedom with minimum external control; maximum free and open communication without fear of retribution or retaliation; emphasis on community and group meetings; staff sharing of decisions with patients wherever possible; rational use of authority and limit setting; minimum rules which are adhered to by all; equality as far as possible between staff and patients; emphasis on here-and-now issues of community concern; responsibility for behaviour a social or therapeutic democracy not a political democracy; avoidance of traditional psychiatric clichés, jargon or techniques; all individual behaviour which effects the community is to be examined in the groups, and finally staff members and patients act as therapists for themselves and others.

The object of this exercise is to increase self-understanding, to help in gaining an increased awareness of interpersonal relationships, and to help in mastering drug problems. "We are here to find ways out of isolation, withdrawal and alienation." A feature of this programme is the use of a 15-minute video tape, where the patient alone with the camera records his feelings and problems and learns to act them out. This tape is erased if after viewing it, the patient so wishes. If he agrees, it is shown to the community and discussed. In addition each patient is expected to make a five to ten minute film as a personal record of himself in general—these films are supposed to dramatize a single idea.

There is a library of films in the unit, and some have been shown to the general public with the patients' permission.

Causes

It is well known that hard drug addiction began on a large scale for the first time during the Civil War and legislative action began with the Harrison Act in 1926. This Act reduced the number initially and medical opinion in the USA favours social change as a major cause rather than social and economic conditions.

Genetic causes are, in terms of inadequacy of the personality, placed highly, but examples are quoted to support the idea of changes in social attitudes leading to confusion in the purposes of living. For example the contrast between the American success story and life as it really is.

Permissive theory in conflict with puritanical tradition leads to interesting situations. The oft quoted example of pre-marital intercourse in the absence of medical advice leading to either pregnancy, venereal disease or both, serves to illustrate the point. The reason frequently given by these girls is that medical advice has not been sought because an initial confession of a breach of the social mores would be required. As in this country, television, cinema and the mass media generally are implicated.

Poor living conditions have been present for a long time and do not fully account for the increase. Disturbed family backgrounds are frequently present in association with the pre-morbid personality.

There has been a decline in the number of negro addicts since the Black Power

movement began to gain strength. Further, the absence of trouble among the Chinese section of the community appears to be significant in this context.

Prevention

Until some five years ago, there was little co-ordinated effort, reliance being placed on punitive legislation. Reasons for this lay in public and medical indifference both of which are evident in this county at the present time. In New York State, the growth of the problem accelerated and in 1966 the state legislature created the Narcotics Control Commission and last year passed further legislation to enable communities to form narcotic guidance councils. These are comprised of three to five members including clergymen, attorneys and physicians.

Among the commission's many activities concerned with the treatment of established cases and research, a Department of Education and Prevention was set up and an attempt was made through the schools to block the development of the non-users, and particularly experimenters into addicts. Resistance to the suggested introduction of drug information into the school curriculum led to the use of teacher instruction courses. Visits to the schools to confront pupils directly with the problem, showing of special films for example, and information leaflet distribution are now increasingly used. Every attempt is being made to bring in the parents. Unfortunately, police intervention in order to implement the law which makes possession a crime operates against these measures to some extent. The law in San Francisco is extremely strict, offenders being sent straight to prison in the first instance so that preventive measures are severely compromised. The relationship between crime and drug possession seems to be as much the result of high black market prices and subsequent fund raising activities as clear-cut criminal action. Even in the case of heroin addicts crimes of violence are rare except between pusher and addict. This means that the intake of the special centres via the courts in New York and the prisons in San Francisco are not representative of the criminal population as a whole.

There is obvious conflict between the medical and police activities but there is evidence that serious attempts are being made to reconcile these differences.

The other major obstacle to successful prophylaxis is the power and influence of the drug trafficking organizations, notably the Mafia. In this country such a complication is as yet not evident.

An attempt to counteract this influence has been made by using deconditioned addicts as feldschers or group leaders, but it is too early to estimate the success of this move.

Treatment of hard drug dependence

The overall results of treatment show little difference in either country. The immediate cure rate is around 20 per cent, but spontaneous cure frequently happens at between the ages of 30-40. The reason for this is unknown even by addicts, so that treatment is directed largely to contain the habit until this resolution occurs. Reported relapse rates vary enormously between New York Hospital Voluntary Patients at 33.3 per cent and New York Riverside at 90 per cent.

While the common problem of a basic personality defect provides the main obstacle to successful treatment, it may be that the criminal flavour injected by the state laws does not help.

Multiple addiction is common, the addict shifting from heroin bags to methedrine and back again on more affluent days. Bags containing one or two per cent heroin in lactose sell at around five dollars, and on average four to eight bags daily are used. That is approximately 80 mg a day. Comparative prices in this country at present would be for a similar quantity of 60 mg; the British price (£1-£5) depending on the source and the American price in the region of 60 dollars.

Since heroin maintenance is illegal, the addict is arrested and confined in hospital and treatment centres in locked wards. By present United Kingdom standards this method seems expensive and probably limited; it does nothing towards solving failure in social integration.

In New York deaths from overdosage are approximately 500 a year, a fact which emphasizes the financial and legal barriers to treatment; this figure is just under 30 per cent of the total number of addicts at present in the United Kingdom.

However, some of this death rate is undoubtedly due to homicidal activities of the pushers who can assassinate a troublesome customer by increasing the bag dose. A sudden increase in concentration above 30 per cent is likely to be fatal. The other principal causes of death are similar to those in this country, that is hepatitis, infection and malnutrition. The main method of treatment used generally is that of weaning under phenothiazines. Methadone substitution is under trial, but there was no firm opinion on the results of this. Recent evidence has suggested that large doses of methadone, that is 100–150 mg daily, have the euphoric qualities of 300–600 mg of morphine. This dosage range has been used in the USA and is much higher than British levels. It seems that all that has been achieved is a switch in direction, rather than weaning by substitution. Cyclazocine is also under trial but considerable patient resistance has arisen because of the side effects, principally nausea.

Psychotherapy is used also in conjunction with phenothiazines, but more extensively in private practice. Centres have been set up in New York for treatment, such as Bay View 180 beds and Cooper Centre 25 beds. The turn round is slow, in the region of one to three years, but attempts are being made to start after-care with the centre as a base. This measure is less impressive than the service provided by self-help organizations in the community, for example Synanon.

Treatment of soft drug dependence

In this field the emphasis is on psychotherapy, and in the sophisticated San Francisco Langley Porter Institute group therapy including audio-visual techniques is used.

Again the problem of multiple addiction appears since early detection may be prejudiced by the system. San Francisco Health Department has several centres for special problems of this kind and the addicts can attend them voluntarily at a cost to themselves of between one to five dollars consultation. While sickness benefits in this country are thought to be too high for fitness incentive in some instances, low relief rates in the United States or even their total absence do not assist in treatment. Addicts receive no financial assistance unless a certificate of psychiatric illness is forthcoming.

Total withdrawal seems to be the aim, but inpatient treatment appears to be limited by high cost as in this country. The community centre approach requires extension, but shortage of personnel in this field acts as a brake on progress. In some of the more recently-equipped centres this numerical shortage is replaced by a rapid turnover in staff as more experienced members move out into other fields. 24-hour, seven-day-a-week cover is provided, which is a sharp contrast to the hours kept at United Kingdom official centres. Patient management in the centres varies from professional team conference decision in hard drug centres to self-run soft drug centres where the staff act as arbitrators, but the patients themselves decide on admission and discharge policy. Results of treatment are better than those of hard drug dependence since the personality inadequacy is less severe and withdrawal presents less of a problem. The burn-out phenomenon does not occur with significant frequency and the adolescent reactive dependents can merge into a chronic state in the adult.

By and large the immediate results are good in young people, but there are no accurate figures because of follow-up difficulties. In San Francisco some thousands of drop-outs arrive in the city for the summer season and leave later in the year.

One of the problems of dealing with cannabis users is the absence of evidence that continual taking is more harmful than say cigarette smoking. At present the evidence suggests that it is less so.

Work is proceeding at the Langley Porter Institute on this problem using a technique of perception analysis. This consists of EEG recording of chronic smokers subjected to various tests. Preliminary evidence does not show any significant brain damage except a general slowing in performance. Reports of liver damage are being investigated in this country. Reports of chromosomal damage from hallucinogens have occurred in both countries.

The future

In a systematized society where material gain linked with social status seems to be the dominant aim and where the assault of the mass media is intense, the pressure on the individual is unlikely to become less. While there is no obvious lack of incentive, the eventual goal appears to be sterile in the eyes of the younger age groups.

Drugs which alter perception and thereby experience, will continue to be attractive to an increasing number throughout all age ranges and social groups. It is difficult to see how real progress can be achieved while social attitudes to this problem remain punitive and mediaeval. This is in contrast to the generally enlightened view taken of other psychiatric problems.

If the medical approach is to be hedged about by penal legislation, progress must continue to be slow. A comparison can be made with the increasing and sometimes emotive legislation in this country which may result in little positive gain other than to introduce the Mafia and strain the police forces even further. In contrast is the adjustment made to this problem by the oriental races in particular and the use of drugs in religious conversion rites. The absence of any association with strong beliefs in society can make artificial controls, particularly when external, self-defeating.

While there is no doubt that the repressive attitude of some American States appear to have produced results in as much as the estimated addiction rate before the Harrison Narcotic Act in 1914 is given as eight times the present figure, the compulsory hospital treatment and relative absence of after-care have not made a significant impression in reducing the size of the problem. Nevertheless it is the duty of those concerned with public health and protection to limit the spread of this disease.

If society is to be comfort-orientated by public demand, drug dependence provides an easy answer. Addiction is generally linked with availability, and legislation directed at drug control only as exemplified by the recent proposal in the United Kingdom to block amphetamine powder at retailer level may provide a partial answer.

There is evidence that punitive legislation and medical progress in this field are incompatible in the USA and in this country panic measures could produce a similar situation. Containment may be achieved but only by a more enlightened society whose reactions are not compounded from lack of knowledge and prejudice.

Acknowledgements

My thanks are due to Drs D. F. Early, Glenside Hospital, J. E. Cates, postgraduate medical dean—both of Bristol, and J. Wright, assistant commissioner, mental health division, New York State, whose generous help made the project possible. Drs S. Seymour Joseph and F. Gamso of N.A.C.C. and A. Simon, director of the Langley Porter Neuropsychiatric Research Institute gave help in the information and access to their departments. The Dr Donald Duncan Bequest Committee provided financial assistance.